

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3301	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2011
NAME OF PROVIDER OR SUPPLIER ALEXIAN VILLAGE OF TENNESSEE		STREET ADDRESS, CITY, STATE, ZIP CODE 671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the survey, there were no deficiencies cited from 1200-8-6, Standards for Nursing Homes.	N 002	K 147 The facility will continue to maintain electrical wiring and equipment in compliance. 1. The electrical junction box on the sixth floor east hall was covered when identified. 2. The Facility Manager reviewed all junction boxes and no other areas were identified to have been affected by this practice. The Facility Manager as of September 16, 2011 educated the electrical contractors on covering all electrical junction boxes. 3. The Facility Manager will review all electrical work for proper completion. 4. The Facility Manager will report all findings to the Quality Assurance Committee monthly time three months.	09/17/11

Division of Health Care Facilities

Matthew T. Fox
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

President & CEO / Interim Administrator

09/15/11

STATE FORM

6899

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If continuation sheet 1 of 1

SEP 16 2011